June 13, 2003

Jenny Babcock
State Children's Health Insurance Program
Health Care Financing Administration
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21224

Dear Ms. Babcock

The Department of Community Health, PeachCare for Kids is submitting a state plan amendment to revise the premium payments required for children ages 6 and older and changes in the screen and enroll process for the Medicaid program.

Should you have any questions, please contact Jana Leigh Thomas, PeachCare for Kids Program Director, at (404)657-9506.

Sincerely,

Gary B. Redding
Commissioner

GBR/jlt
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changes.

CONTINUING ENROLLMENT

At the time of application approval, the family receives information requiring them to report changes in their income, place of residence or household size to the TPA. If these changes result in ineligibility, the TPA reviews the account information for potential eligibility for the Medicaid program. If the child is potentially eligible, the account information is sent to the State Medicaid staff for review, just as the new applications are handled.

If the child is screened as ineligible for Medicaid and PeachCare for Kids based on the information provided, the TPA sends the member a notice of termination and closes the case. The notice specifies the reason for termination (e.g. excess income, age over eighteen years etc.) The notice also specifies the applicant's opportunity to request a reconsideration of the decision and related procedures to submit any necessary documentation.

As long as the family continues to meet all eligibility requirements and continues to pay the monthly premium as required, the child(ren) may be eligible for coverage for twelve (12) months.

PREMIUM COLLECTION and REINSTATEMENT PROCESS

- Premiums: Children ages 0-5 $0
  Children ages 6-18 $10.00 (1 child)
  $15.00 (2 or more children below 150% FPL)
  $20.00 (2 or more children 151 to 235% FPL)
  - The applicant must submit 1 month's premium, if required, with the application for it to be complete. Once determined eligible, enrollment becomes effective the first day of month in which a complete application was received.
  - When the applicant is enrolled, the TPA sends a coupon payment book (or other payment mechanism) to the member for use in making regular premium payments. Members may send in premiums for multiple months.
  - The first two month's coverage will be funded with state/federal funds. The premium sent with the application will be applied to the third month's coverage. With this model, the collection process will be one month ahead of coverage and

an member has 30 days after being late with a payment to submit it before coverage is terminated.

- If payments are late, the notification/cancellation process will begin. Two letters will be sent before cancellation occurs.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

- None for children under the age of 6;
- For children ages 6 through 18: $10.00 per month for 1 child
- For children ages 6 through 18: $15.00 per month for 2 or more children in households with income at or below 150% FPL
- For children ages 6 through 18: $20.00 per month for 2 or more children in households with income between 151 and 235% FPL

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments: None

8.2.4. Other: None

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The maximum a family could have to pay is $240 annually. This is the maximum family premium of $20 times 12 months. Since there are no deductibles, coinsurance, co-payments or other cost sharing methods, the annual aggregate cost sharing is the maximum family premium annually. In order for $240 to exceed 5 percent of a family's annual income, the family's annual income would have to be below $4,800. Uninsured children in a family with annual income below $4,800 would be eligible for Medicaid rather than PeachCare for Kids, if they met the other eligibility criteria in addition to income criteria. Therefore, with such a low cost-sharing requirement, PeachCare ensures that the aggregate cost sharing for a family never exceeds 5 percent of a family's annual income.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

Planned use of funds, including --

- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

PeachCare Federal Fiscal Year 2004 Projections
Assumptions:

- Projected membership = 207,554 average monthly enrollment for the Federal Fiscal Year

Benefit Expenditures	$ 302,651,523
Administrative Expenditures	$9,046,241
TOTAL (less premiums)	$297,978,883
Federal Share	$213,680,657
State Share (all General Fund)	$79,327,521
Premiums	$13,718,881
Tobacco	$ 4,970,705

Explanation of Expenditures

1. Benefit Expenditures

This line item reflects the reimbursements to providers for the provision of health care services to the PeachCare members.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

PeachCare for Kids utilizes the same income methodologies as are used for its Right from the Start Medicaid program (Title XIX Poverty Level Group), ensuring that there are no gaps or overlap in income eligibility for PeachCare for Kids and Medicaid based on income sources or income disregards.

Upon receipt of the application, the TPA screens the application for potential Medicaid eligibility. If the child is potentially Medicaid eligible based on reported income, the TPA will route the application to centralized Right from the Start Medicaid (RSM) staff for a determination of Medicaid eligibility. The child's application is entered into SUCCESS, the state's eligibility system for Medicaid, Food Stamps, and TANF. The RSM staff notifies the TPA of the outcome of all applications. The denial reasons and any additional income information is included for the TPA to reevaluate the application for potential eligibility for PeachCare for Kids. If it is determined that the income is within the PeachCare eligibility guidelines, the TPA will enroll the child in PeachCare for Kids without requiring the parent to complete an additional application.

Prior to enrollment, each child who is screened for potential PeachCare eligibility is checked against the Medicaid information system for enrollment in Medicaid. The record of each child is also checked with the State Health Benefit plan for enrollment of the child or a parent in the state health insurance plan.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially

eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

Upon receipt of the application, the TPA screens the application for potential Medicaid eligibility. If the child is potentially Medicaid eligible based on reported income, the TPA will route the application to centralized Right from the Start Medicaid (RSM) staff for a determination of Medicaid eligibility. The child's

application is entered into SUCCESS, the state's eligibility system for Medicaid, Food Stamps, and TANF. The RSM staff notifies the TPA of the outcome of all applications. The denial reasons and any additional income information is included for the TPA to reevaluate the application for potential eligibility for PeachCare for Kids. If it is determined that the income is within the PeachCare eligibility guidelines, the TPA will enroll the child in PeachCare for Kids without requiring the parent to complete an additional application.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Since the inception of PeachCare for Kids DCH has worked closely with DFCS to promote the program. The PeachCare for Kids application requests all of the information necessary to determine Medicaid eligibility for a child. DFCS offices use this application for parents who are only seeking coverage for their children. If the children are determined to be ineligible for Medicaid, the caseworker mails the application to PeachCare for processing, without requiring the family to complete an additional form or application.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☑ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

A child will be denied eligibility if it is determined that he or she: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or 3) is a member of a family that is eligible for health benefits coverage under a State health
benefit plan based on a family member's employment with a public agency in the State; or 4) voluntarily dropped coverage

under an employer plan during the past three months. (Voluntary termination of coverage does NOT include the following: employer cancellation of the entire group plan; loss of eligibility due to parent's layoff, resignation of parent from employment,